



COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
239 CAUSEWAY STREET, SUITE 500
BOSTON, MA 02114
800-414-0168
www.mass.gov/dph/boards

**PHYSICIAN ASSISTANT LICENSE APPLICATION
INSTRUCTIONS AND CHECKLIST**

Please read these instructions carefully. All supporting materials must be submitted at the same time. Applications will not be reviewed by the Board until all documentation has been received.

General Information About the Application Process:

The Board of Registration of Physician Assistants ("Board") highly recommends that you refrain from accepting a Physician Assistant position in Massachusetts until you are licensed.

Once an application is received by the Board, it takes a minimum of **3- 5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested. **DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing of application. Incomplete applications will be returned to applicant.

Complete applications must include the following documents:

- ☐ Completed application form with 2x2 passport style color photo and notary signature.
- ☐ Official transcripts in signed, sealed envelopes from all undergraduate programs/degrees, physician assistant programs/degrees and any other post-secondary programs/degrees. When requesting official transcripts, please inform each school's registrar that the **transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.** Transcripts may be sent directly to the Board by the institutions. Transcripts pending completion may be accompanied by an **ORIGINAL** certified letter from the Registrar's Office verifying:

- a. the completion of all requirements for a degree; and,
- b. the anticipated date of graduation. **Applicants must have graduated from a physician assistant program before a license can be issued.**

NOTE A: If transcripts have been previously submitted with an application for a Temporary Practice Certificate, they do not need to be resubmitted, if they were submitted within the past 12 months.

NOTE B: Board statute at M.G.L. Chapter 112, § 9I requires that an applicant for licensure as a physician assistant shall provide **satisfactory proof of having received a bachelor's degree** from an accredited college or university; Board regulations at 263 CMR 3.02 (2)(b) require that any person seeking a license to practice as a physician assistant must possess a baccalaureate degree from an educational institution accredited by the US Department of Education.

- ❑ NCCPA documentation of certification is required. This must be sent directly from NCCPA; email verifications are not acceptable. A form to request NCCPA verification is included in the application packet.
- ❑ An official Physician Assistant Information Profile from the Federation of State Medical Boards' **Federation Credentials Verification Service (FCVS)** may be submitted in lieu of transcripts and NCCPA documentation. If you are registered with FCVS and are using this service for your application, please so inform the Board. For more information about the FCVS Profile, visit the FCVS web site at www.fsmb.org.
- ❑ Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now or have ever held any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdictions.

NOTE: If verifications have been previously submitted with an application for a temporary practice certificate, they do not need to be resubmitted if they were issued within the past 12 months.

- ❑ If you hold, or have ever held, any professional license, you must request and submit a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query. To request a Self-Query, please contact The National Practitioner Data Bank at 1-800-767-6732 or at www.npdb-hipdb.com. Include the **ORIGINAL** report with this application; make a copy for your records.

NOTE A: If you do **NOT** hold and have never held any professional licenses in any other state, you do not need to submit a National Practitioner Data Bank self-query.

NOTE B: If a National Practitioner Data Bank self-query was submitted with an application for a temporary practice certificate, it does not need to be resubmitted with an application for full licensure if it was the **ORIGINAL**, certified and sent within the past 12 months.

- ❑ Submission of the Criminal Offender Record Information Acknowledgement Form (CORI).

NOTE: The Board of Registration in Physician Assistants cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a DHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

- ❑ Supervising Physician form, if applicable. Your license may be issued without this form; however, it must be On File with the Board within thirty (30) days of beginning employment. A MA Board of Registration in Medicine Physician Profile must be attached. Profiles are available on line at www.massmedboard.org.
- ❑ Work Setting Information form, if applicable. Your license may be issued without this form; however, it must be on file with the Board within thirty (30) days of beginning employment.

NOTE A: If there has been no change in supervising physician[s] and/or work setting[s] since a Temporary Practice Certificate was issued, new forms do not need to be resubmitted.

NOTE B: Multiple supervising physicians and work settings require submission of separate forms for each supervising physician and each work setting.

- ❑ Check or money order payable to the Commonwealth of Massachusetts for \$225.00. Cash or foreign currency is not accepted.

NOTE: If you hold a Temporary Practice Certificate you must pay this fee in addition to the fee previously paid for Temporary Practice Certificate.

- ❑ Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for physician assistant licensure are not met within one (1) year from the date of Board receipt of this application. All fees are non-refundable and non-transferable.
- ❑ Application must be submitted on single-sided paper.
- ❑ Retain a copy of the completed application for licensure for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.

- All submissions and documentation for agenda items must be received by the Board at the close of business on the Monday of the week preceding the scheduled Board meeting. Materials received after the deadline will be reviewed prior to being placed on the agenda for the next scheduled meeting.

IMPORTANT INFORMATION:

Pursuant to 263 CMR 3.04 (4), Board regulations state that a physician assistant applicant/registrant must notify the Board in writing of any of the following events within thirty (30) days of their occurrence: change of address of applicant/registrant; change of identity of the applicant/ registrant's employer or employment status of the applicant/registrant; any change in the identity or address of the registered physician supervising the practice of the applicant/registrant; or, the permanent departure of the applicant/registrant from the Commonwealth of Massachusetts.

Failure to update your address may result in failure to receive a license renewal application and expiration of your license.

The address printed on your license is a **PUBLIC RECORD** that is available to anyone who requests it. If you are using your home address, you may wish to consider changing this to an office address. Address changes may be done online at the board's website www.mass.gov/dph/boards/pa or you may obtain a form online to submit to the Board's office. Retain a copy of the completed application for licensure and related documentation for your records. Employers may require that you provide them with a copy.

Answers to many questions may be found on the Board's website. Statutes and regulations governing physician assistant licensure and practice may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168.



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COMPLETE ALL QUESTIONS
License Application Fee - \$225.00

1. Applicant Name: _____
Last First Middle
a. Maiden Name/Other Name (if applicable):

Last First Middle
2. Temporary Practice Certificate Number (if applicable): _____
3. Address of Record: _____
No. Street Apt. #

City/Town State Zip Code
4. Most Recent Previous Address: _____
(Different then Address of Record No. Street Apt. #
- MUST BE FILLED IN)

City/Town State Zip Code
5. Telephone Number(s) Day: _____ Evening: _____ Cell: _____

6. _____ / _____ / _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)
HEIGHT: _____ Feet _____ Inches WEIGHT: _____ Lbs. EYE COLOR: _____
Sex: M F (Circle One) MOTHER'S MAIDEN NAME: _____
Email: _____

7. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory): _____ / _____ / _____
Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

FOR BOARD USE ONLY

Application Number: _____ Receipt Number: _____
License Number _____ PA Temporary Practice Number: PAT _____

EDUCATION

8. NCCPA Certificate Number: _____ Expiration Date: _____

Applicant must arrange for official written documentation of certification to be sent directly by the NCCPA.

9. PA Program Name/Location: _____

Degree awarded: _____ Date of Graduation: ____/____/____
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board. Note: If transcripts were previously submitted with an application for a temporary practice certificate, they do not need to be sent a second time.

Bachelor's Degree School Name/Location: _____

Degree: _____ Date Awarded: ____/____/____
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board.

Other post-secondary Institution(s)/Location(s): _____

Degree: _____ Date Awarded: ____/____/____
(mm/dd/yyyy)

Please list additional post-secondary educational institutions on a separate sheet and request that transcripts be submitted directly to the Board as noted above.

VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

10. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS

☐ I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

| <u>Issuing State/Jurisdiction</u> | <u>Profession</u> | <u>License/Certification Number</u> |
|-----------------------------------|-------------------|-------------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board in a signed, sealed envelope.

QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

11. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

12. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

13. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

14. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$250 or less was imposed.

Yes ☐ No ☐

16. Have you ever been court martialled or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Physician Assistants any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Physician Assistants to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a Physician Assistant, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed Physician Assistant in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a Physician Assistant shall be deemed no longer valid if requirements for full licensure as a Physician Assistant are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration of Physician Assistants to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent
passport
photo
(2x2)

NOTARY NAME: _____

COMMISSION EXPIRES: _____

[Seal]

INCLUDE A NONREFUNDABLE FEE OF \$225.00 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS



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**SUPERVISING PHYSICIAN FORM
FOR
TEMPORARY PRACTICE CERTIFICATE AND
LICENSE APPLICATIONS**

Complete this form and submit it to the Board with application for a Temporary Practice Certificate or License Application. If you are not employed at the time of application for a Temporary Practice Certificate or a License, return this form to the Board at the above address within thirty (30) days of beginning employment in the Commonwealth of Massachusetts. If you have more than one supervising physician and/or work setting, you must complete and submit a separate form for each supervising physician and each work setting.

Applicant/PA Name: _____
Last First Middle License/Temp Prac #

Applicant/PA
Address: _____
No. Street City/Town State Zip Code

Date of Employment: _____

Physician Name: _____
Last Firs Middle License# Specialty

TO BE COMPLETED BY SUPERVISING PHYSICIAN:
List all physician assistants currently under your supervision:

Name: _____ Lic Number: _____

Name: _____ Lic Number: _____

Name: _____ Lic Number: _____

Name: _____ Lic Number: _____

If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.

I. Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

☐ Yes ☐ No

II. Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

☐ Yes ☐ No

III. Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

☐ Yes ☐ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

Signature of Supervising Physician

Date

A MA BOARD OF REGISTRATION IN MEDICINE PHYSICIAN PROFILE MUST BE ATTACHED. PROFILES ARE AVAILABLE ON LINE AT WWW.MASSMEDBOARD.ORG. SEND THE PROFILE AND THE COMPLETED FORM TO THE MA BOARD OF PHYSICIAN ASSISTANTS AT THE ADDRESS ABOVE.



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**WORK SETTING INFORMATION
FOR
TEMPORARY PRACTICE CERTIFICATE AND
LICENSE APPLICATIONS**

Complete a separate copy of this form for each work setting in which you are employed as a physician assistant. If you are not employed at the time of application, return this completed form to the Board of Registration of Physician Assistants, 239 Causeway Street, Boston, MA 02114 within thirty (30) days of commencing employment.

APPLICANT NAME:

Last First Middle License/Temp. Practice #

NAME OF FACILITY OR OFFICE: _____

ADDRESS: _____

EFFECTIVE DATE: _____

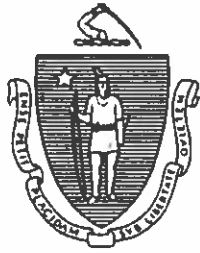
TYPE FACILITY: Office () Clinic () HMO () Hospital () Other: _____

TYPE EMPLOYMENT: Full time () Part time ()

LIST NAMES OF MASSACHUSETTS'S HEALTH CARE FACILITIES (INCLUDING GROUP PRACTICES) AT WHICH YOU WILL PRACTICE OR BE AFFILIATED WITH IN THIS WORK SETTING:

CHECK ALL AREAS OF PRACTICE THAT APPLY TO THIS SETTING:

- | | | |
|---|--|--|
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Administration | <input type="checkbox"/> Emergency Medicine |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Geriatric Medicine | <input type="checkbox"/> Education | <input type="checkbox"/> Clinical Research |
| <input type="checkbox"/> Obstetrics/Gyn. | <input type="checkbox"/> Pediatrics/Adolesc. | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> Oncology | <input type="checkbox"/> Dermatology | <input type="checkbox"/> Cardiology |
| <input type="checkbox"/> Medical Specialty _____ | | |
| <input type="checkbox"/> Surgical Specialty _____ | | |
| <input type="checkbox"/> Other _____ | | |



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NCCPA CERTIFICATION REQUEST FORM

COMPLETE THIS FORM AND MAIL IT TO:

NCCPA
12000 Findley Road, Suite 200
Duluth, GA 30097-1409

Retain a copy for your records.

I hereby authorize and direct the National Commission on Certification of Physician Assistants, Inc., to release to the

Massachusetts Board of Registration of Physician Assistants
239 Causeway Street, Suite 500
Boston MA 02114

any and all information concerning my eligibility, examination, and/or certification status, and/or examination scores which the Massachusetts Board of Registration of Physician Assistants may require in conjunction with my application for registration. I hereby release the National Council on Certification of Physician Assistants, Inc., and its agents and employees from any liability arising out of its compliance with such a request for information.

SIGNATURE OF APPLICANT _____

DATE _____

1A. APPLICANT NAME: _____

LAST

FIRST

MIDDLE

1B. PREVIOUS NAME: _____

LAST

FIRST

MIDDLE

2. ADDRESS: _____

No.

STREET

APT. #

CITY/TOWN

STATE

ZIP

3. DAY TELEPHONE NUMBER: _____

4. DATE OF BIRTH: ____/____/____

(MM/DD/YYYY)

5. SOCIAL SECURITY NUMBER: ____-____-____

6. NCCPA CERTIFICATE No.: _____

7. DATE OF EXAM: ____/____/____
(MM/DD/YYYY)



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(617) 973-0800

**FEDERATION CREDENTIALS VERIFICATION SERVICE
(FCVS)**

Federation Credentials Verification Service (FCVS) was established in September 1996 to provide a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials.

This service is designed to lighten the workload of credentialing staff and reduce duplication of effort by gathering, verifying and permanently storing the physician's and/or physician assistant's credentials in a central repository at the Federation of State Medical Board's offices.

FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician and/or physician assistant to establish a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the physician's request, to any state medical board that has established an agreement with FCVS, hospital, health care or any other entity.

FCVS Physician Assistant

Applicants who complete the verification process establish a permanent, lifetime portfolio of primary-source verified credentials-allowing quick, easy and inexpensive access to medical credentials. These documents can be used throughout the applicant's career for state licensure, hospital privileges, employment and professional memberships.

Contact: www.fsmb.org